thank General Moore for his service and wish him the best in his new and important assignment as Deputy Director of the Defense Threat Reduction Agency—an agency that will become the Department of Defense's focal point for addressing the many serious threats associated with weapons of mass destruction.

Mr. Speaker, General Moore has served the nation and the Air Force admirably for over 31 years. Throughout his career, the nation has asked a lot of General Moore and his family—his wife, Carol, and their two daughters, Rachel and Laurel. I want to congratulate General Moore on his new assignment, thank him for the job he has done during the past three years as Director of Special Programs, and wish him, and his family, health, happiness and prosperity in the future.

TRIBUTE TO COL. LAWRENCE W. STYS, WISCONSIN WING COMMANDER OF THE CIVIL AIR PATROL

HON. GERALD D. KLECZKA

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 9, 1998

Mr. KLECZKA. Mr. Speaker, I rise today to honor a skilled pilot and dedicated public servant, Col. Larry Stys, Wisconsin Wing Commander of the Civil Air Patrol. After 33 years with the CAP, Col. Stys will step down as the Wisconsin Wing Commander October 17.

His lasting legacy is a record unparalleled in the history of the Civil Air Patrol in Wisconsin. He achieved this by hiring the best individuals for duty assignments and inspiring them to the highest principles. Mr. Speaker, perhaps the philosophy of Col. Stys can best be expressed in his own words written to all Wisconsin Unit Commanders:

''I realized that the most important thing in one's life was principles. If one's life was ordered to and grounded in a set of principles, the arrangement of things will fall into line automatically. Principles are more than character traits. Traits can sometimes be worn without truly believing in them. This fundamental basis of character is called integrity. People can look at you and believe you. You can persuade without recourse to cajole.''

This philosophy enjoyed obvious success, Mr. Speaker. In 1995, Wisconsin Wing was named best in the region in Search and Rescue proficiency.

And in 1997 during the Air Force Quality Inspection, Wisconsin Wing earned the distinction as best in the nation, excelling in all categories, including an unprecedented 13 benchmarks, which other wings will be rated against. Despite these laudable achievements, Col. Stys repeatedly deflected praise from himself to his staff.

Mr. Speaker, volunteer service is held in such high regard because of the dedication and professionalism of men like Col. Stys. As he leaves his command, we commend his invaluable service, we celebrate his contributions to air safety, and we salute his high regard for standards and principles.

TRIBUTE TO STATE SENATOR RALPH DILLS

HON. GEORGE MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 9, 1998

Mr. MILLER of California. Mr. Speaker, I ask the House to join me in recognizing the retirement of the senior member of the California State Senate, Sen. Ralph Dills. Sen. Dills will leave office at the end of the year, and in August completed his last session in a career that began 60 years ago.

I had the pleasure to know Sen. Dills when I worked as an intern and a staff person in the state Senate in the 1960s and 1970s. A colleague of my father, who was himself a senator then, Sen. Dills was even in those days an institution in Sacramento, and he certainly remains one today.

We all honor his devotion to public service and to the people of the state of California. I would like to submit an editorial from the Sacramento Bee that pays tribute to this distinguished legislator and Californian, and I know all members of this Congress join me in honoring his career.

[From the Sacramento Bee, Sept. 2, 1998]

RALPH DILLS BOWS OUT: SENATOR WAS THE STATE'S LONGEST-SERVING LAWMAKER

Franklin Roosevelt was serving his second term as president when Ralph Dills was first elected to the California Legislature in 1938. President Clinton wasn't yet born, nor were most lawmakers with whom Dills now serves.

Dills arrived in Sacramento from Long Beach, a liberal New Deal Democrat and staunch friend of labor, and he departs 60 years later much the same way. In 1949, he left the Assembly to accept a judgeship, but 17 years later he was elected to the Senate, where he has been ever since, often presiding over sessions, a chore he relished.

One of Dills' proudest achievements was authoring the law that created Long Beach State University; another was the 1977 measure that gave collective bargaining rights to state workers. In speeches lauding him last week, fellow lawmakers remembered that Dills was among a small minority of legislators who opposed the internment of Japanese Americans during World War II.

As a senator, Dills presided over the influential Governmental Organization Committee. The panel handles liquor, horse racing and gambling legislation and has traditionally been a channel for large campaign contributions that Dills used to help keep himself and his fellow Democrats in power.

In his later years, Dills was known less for his legislative prowess than for his colorful attire, purple-tinted hair and saxophone playing. Reapportionment had pushed his district westward, from a gritty inland neighborhood to a more upscale coastal area, forcing him to acquire an environmental sensitivity he'd never shown before. He was 88, ailing and in a wheelchair when he cast his last votes in the Legislature late Monday. However he is ultimately rated, term limits ensure that Ralph Dills' durable presence in Sacramento is unlikely to be repeated.

WHY PATIENT COST-SHARING SAVES LITTLE: THE HEALTH LESSONS FROM EUROPE

HON. PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 9, 1998

Mr. STARK. Mr. Speaker, various Members of Congress frequently say that one of the ways to save Medicare is to require the patient to pay a higher share of the cost—thus making the patient a more careful consumer and reducing the demand for care.

Following is a portion of a 1997 study published by the World Health Organization entitled, ''European Health Care Reform,'' which shows why such an approach will save little, but of course will greatly increase the burden on the poorest and sickest in our society. This portion of the study is also interesting in that it shows that in most foreign countries, patients have much more time with their doctor and have much longer hospital length of stays than Americans—yet those foreign societies spend about 30 to 40% less than we do on health care.

Before Americans push more of the burden of Medicare onto the poor and sick, we should look to the lessons from abroad.

THE EFFECTS OF COST SHARING

TOTAL HEALTH EXPENDITURE

Evidence suggests that cost sharing reduces utilization but does not contain costs. Overall costs are not contained because cost sharing is a set of demand-side policies, and costs are primarily driven by supply-side factors. Intercountry comparisons indicate that the United States has lower rates of contact with physicians and beddays per head of population than many other countries, including Canada, France, Germany, Japan and the United Kingdom, but costs in the United States are much higher relative to GDP than in these other countries. This strongly suggests that it is the intensity of care provided per contact in the United States that is responsible for this apparent paradox *(198)*. The United States has the highest out-of-pocket expenses, mostly to meet cost-sharing obligations; it also has the highest overall costs. Other countries have lower cost-sharing and higher utilization rates, but lower costs. This does not mean that cost sharing causes higher costs; it means that measures other than cost sharing (supply-side measures such as budgetary controls) are much more effective mechanisms for cost-containment.

The Rand Study *(199,200)* suggests that cost sharing is associated with a decrease in total health spending, but the design of the experiment does not really permit strong conclusions to be drawn about the consequences for total expenditure of the broad implementation of cost sharing within a retrospective reimbursement system. The reason is that providers may compensate for a reduction in consumer-initiated demand by inducing increases in service volume or intensity. Table 9, which shows intercountry data *(198)* on contacts with physicians, hospital days and health expenditure as a percentage of GDP, suggests that consumer-initiated demand is not the major factor driving health care costs. Rather, it appears to be the intensity of services provided. Since intensity is largely provider initiated, there is little scope for cost sharing to make much of an impact on the overall level of spending. . . .

TABLE 9. HEALTH CARE UTILIZATION AND EXPENDITURE IN SELECTED COUNTRIES, AROUND 1990

Country	Contacts with physicians per head	Bed-days per head	Expenditure as a percentage of GDP
Canada	6.9	1.5	9.5
France	7.2	1.5	8.8
Germany	11.5	2.3	8.3
Japan	12.9	—	6.7
United Kingdom	5.7	0.9	6.2
United States	5.5	0.9	12.2

EQUITY IN FINANCING

Has cost sharing led to a relatively greater burden of health care financing falling on lower-income households? Based on data from the 1980s, Switzerland and the United States were found to have the most regressive health financing systems out of ten OECD countries studied *(201)*. This finding was attributed to their heavy reliance on both private health insurance and private out-of-pocket payments. The latter were found to be very regressive in these two countries because, in most instances, cost-sharing obligations apply irrespective of the patient's income.

The equity consequences of cost sharing in France are unclear, because there is no direct relationship between income and complementary insurance coverage. Employees in small firms and young people, as well as the unemployed, are less likely to have complementary insurance. This suggests that voluntary complementary insurance that cover the cost-sharing obligations of a national insurance system can lead to a disproportionate financial burden (and probably inequitable access as well) for those unable to purchase that coverage.

Evidence from Kyrgyzstan suggests that the mix of formal and informal charges to users of health services increased inequities in financing. The out-of-pocket costs of a single episode of illness could impose a substantial financial burden on many households. In 20% of cases, the total costs of an episode for an individual exceeded the monthly income of his or her entire household. Almost 50% of inpatients reported severe difficulties in finding the money to pay for their stay, and one third of them borrowed money to pay for their hospital charges. Capital items were often sold (farm animals in rural areas, consumer goods in urban areas) to raise the necessary money. Overall, there is evidence that the incidence of out-of-pocket payments for health is inequitable, i.e. it creates more of a burden for poorer households and individuals *(197)*.

CONCLUSION

Cost sharing does not provide a very powerful policy tool, either for improving efficiency or for containing health sector costs. Because of the importance of providers in influencing the main drivers of health sector costs, policies that address the supply side of the market are likely to be much more powerful than those that act solely on the demand side. Cost sharing will reduce consumer initiated utilization, but such reductions will not be effective for cost-containment. This is because the main influence on health care costs is service intensity, which is provider driven.

The appropriateness and likely effects of cost sharing depend on the services to which it is applied, and on the broader context of the provider payment system. The use of cost sharing as a tool to limit demand is relevant only when applied to first-contact services. For (provider-initiated) referral services, cost sharing has little impact on utilization and is thus of little relevance in terms of efficiency. In systems in which providers are reimbursed retrospectively, reductions in consumer-initiated utilization caused by cost sharing will encourage providers to increase the volume of services per patient contact (i.e. service intensity) in order to maintain their incomes. In such systems, therefore, cost sharing does little to restrain cost growth because the available evidence suggests that providers can—and do— respond to a drop in consumer-initiated utilization by stimulating an increase in the use of diagnostic and therapeutical services. In systems where providers are prepaid, there are no obvious incentives for this response, but the effects of cost sharing are still likely to be marginal because supply-side incentives are enough to restrain growth in expenditure.

Without compensatory administrative procedures, cost sharing causes inequity in the financing and receipt of health services. Unless cost sharing is related to income, co-payments and co-insurance will impose a greater burden on the budgets of low-income households. Without specific measures to exempt low-income groups from out-of-pocket charges, access to care will depend on income levels. Evidence consistently shows that direct charges deter poorer people from using services to a greater degree than they deter the better-off. These limitations on access may result in adverse health effects for poorer and sicker groups of the population. To protect equity, therefore, measures are needed to compensate for the consequences of cost sharing on poorer members of society.

As a means of mobilizing revenue for the health services, direct charges to patients are not likely to generate substantial amounts without causing adverse consequences in terms of equity.

LITERACY IN AMERICA

HON. LEE H. HAMILTON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 9, 1998

Mr. HAMILTON. Mr. Speaker, I would like to insert my Washington Report for Wednesday, August 5, 1998 into the CONGRESSIONAL RECORD.

LITERACY IN AMERICA

In the course of a recent conversation I had with an older Hoosier woman, she acknowledged to me, with tears in her eyes, that she could not read. She told me she was unable to read the local newspaper, compute the numbers in the supermarket, write to her children, or read the Bible. I could scarcely imagine how a person could function in today's world without being literate. Yet many people do. More than one out of every five Americans cannot read or do simple math. That is a shocking figure with huge ramifications for the quality of life for many of our fellow citizens and for the country's economic and political well-being.

Defining literacy: In years past, literacy was simply defined as a person's ability to read and use printed materials at a very basic level. But the increasing complexity and change in today's society, along with the skills demanded of individuals, has led to a more comprehensive definition.

Today, the definition of literacy most widely used in the U.S. actually is not a single definition, but involves five different levels of proficiency. The lowest level of literacy, or Level 1, is marked by a difficulty in locating an intersection on a map, completing background information on a Social Security card application, or other rudimentary tasks. The highest level, or Level 5, involves college-level reading and writing skills.

Literacy and employment: Over time, even as definitions and measures of literacy have changed, each was largely based on what is needed for gainful employment. As the workplace changes, what it means to be literate also changes. Today's workplace requires higher levels of critical reading, problem solving, and computer skills to ensure success. Our economy has become increasingly high-tech and demands higher literacy and technical skills for jobs like data processing, communications, and finance. A two-tiered workforce has evolved, one with the literacy skills needed for the old economy, and a second with advanced skills for the high-tech workplace. Such a two-tiered economy would leave a significant portion of workers behind, and present formidable challenges to the nation.

Literacy levels have real implications on salary levels. On average those in the highest level are paid over $400 more per week than those in Level 1.

Trends in literacy: Since at least the 1980s, the literacy levels of Americans have continued to slump. Ten years ago one out of every five American adults age 16 and over could not read and write at the most basic levels. Today, the best estimate is that 23%, or 44 million adults, are at Level 1 literacy. In Indiana, an estimated 16% of adults are at Level 1, with the percentage slightly lower—about 14%—in the 21 counties of the Ninth District.

Low literacy levels contribute to many other problems. Of adults in the Level 1 category, 43% live in poverty. Some 75% of those on food stamps placed in the lowest two levels of literacy skills. People at Level 1 averaged 19 weeks of work per year compared to 44 weeks for Level 5. Also, seven out of ten people in correctional facilities performed in the lowest two levels.

Literacy programs: Help is available today for those with literacy needs, but often it is not received because many persons with low literacy levels feel they either do not have a problem or do not admit to such a problem. One successful way of breaking the cycle of poor literacy skills has been through local family literacy programs, which include four elements: adult education and employment skills, early childhood education, parent support groups, and opportunities for educational parent-child interaction. Studies show that these family programs enable children to read much better. These programs also are helpful for the whole family as 23% of families on public assistance become self-sufficient after successfully completing the program. These family programs increase motivation and self-esteem in adults, give people a chance to discuss and share concerns with their peers, and allow parents and children to develop skills in a positive and structured environment. Other literacy and education programs in workplaces and libraries, and for non-English speakers have been effective as well. Also, particularly effective are programs for the incarcerated. Re-arrest rates for prisoners are significantly lower if they participate in an education program while in prison. Unfortunately, the participation rate for such programs is low.

Congressional involvement: Although the majority of literacy initiatives are state and local, the federal government plays an important supporting role. Last year, Congress provided $361 million for federal adult education and literacy programs. Most of these funds provide grants to states, support prison literacy programs, and underwrite literacy study and research initiatives. Last year, Indiana received over $7 million in federal funding for literacy programs.